with patients with forms of hand-foot syndrome of varying severity, which yielded a detailed and rigorous collection of verbatim transcripts. **RESULTS:** Thirty-one items were identified, and 14 items were selected as being relevant and non-overlapping after initial evaluation. The first question in the HFS14 addresses which member is affected (hand, foot or both). The second question addresses the pain with three possible responses (very, moderately or not painful). The 14 items can be organised in 2 modules: the first module more specifically assesses the handicap generated by involvement of the "feet" and the second assesses the handicap generated by involvement of the "hands". Six (6) items are considered common to both modules, 4 are hand-specific and 4 are foot-specific. Psychometric validation confirmed the internal consistency and very high reproducibility of the questionnaire. **CONCLUSIONS:** The hand-foot syndrome-specific HFS14 scale is easy to use and meets the requirements of a quality of life scale. This scale now needs to be tested in longitudinal studies (for example in clinical trials) to confirm its ability to measure a change in status.

PMC54

ESTIMATING SOCIAL PREFERENCES FOR EQ-5D IN TURKEY : A NOVEL METHOD BASED ON A VALUATION EXCHANGE-RATE MECHANISM

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OBJECTIVES: To estimate a set of Turkish social preference weights for EQ-5D health states in a 2-stage process that a) establishes the relationship between VAS ratings for *real* (self-reported) health states in UK and Turkey, and b) applies this functional relationship to adjust UK utilities for *hypothetical* EQ-5D health states for use in Turkey as proxy social preferences. **METHODS:** A stratified sample of the general population in Turkey was drawn, based on 7 geographical provinces and adjusting for rurality. 7000 individuals aged 18 and above were randomly selected from district registers in 14 cities and invited to participate in face-to-face interviews conducted at home or in the workplace. Of the 5676 (81%) who were contacted 4,990 (71%) completed the interview which included the Turkish language version of EQ-5D. **RESULTS:** The mean age of the sample was 39.5 (range18 to 70) of whom 57% were female. The sample was deemed to be broadly representative of the general population in Turkey. Mean VAS ratings for self-assessed health status was 70.1 (range 5–100). A total of 49 self-reported EQ-5D health states identified in the Turkish survey were also found present in a UK database containing corresponding EQ-5D data (n~23,000). Although non-linear functional forms were tested, an OLS regression model proved to be the most efficient function linking the mean VAS values for these states in the Turkish data with the equivalent VAS values in the UK database : $VAS_{Turkey} = 0.901 * VAS_{UK}$ ($r^2 = 0.989$, $p < .001$). This function was then applied to the existing set of UK social preference weights to produce an estimated value set for use in Turkish economic evaluation. **CONCLUSIONS:** A novel method of estimating EQ-5D preference scores for countries without their own domestic value set appears feasible.

PMC55

AGREEMENT BETWEEN PATIENT AND PROXY ASSESSMENT OF HEALTH-RELATED QUALITY OF LIFE BEFORE INTENSIVE CARE UNIT ADMISSION

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OBJECTIVES: The aim of this study was to assess the agreement between patient and proxy respondents on health-related quality of life (HRQOL) before intensive care unit (ICU) admission. **METHODS:** The present study (from January 15 to March 1, 2009) is part of a larger prospective longitudinal cohort study evaluating the cost-effectiveness of ICU admission. A 107 adult, cooperative patients consecutively admitted >24 hours to the ICU of a tertiary care referral centre, and their proxies were interviewed. The instruments used included the Short Form 36 (SF-36) and the EuroQol 6D (EQ-6D). Baseline characteristics of both patient and their proxy were also collected. **RESULTS:** Of participating patients (n = 107), 79 (73.8%) were admitted to the surgical ICU, and 28 (26.2%) to the medical ICU. When comparing the participating vs. non-participating group, the latter were older (54.4 ± 17.1 vs. 59.6 ± 17.2, p = 0.018), were more ill according to SOFA (3.9 ± 2.8 vs. 5.2 ± 4.0, p = 0.001) and APACHE II score (15.2 ± 6.9 vs. 18.8 ± 9.6, p < 0.001), and had worse outcome according to ICU and hospital mortality (0% vs. 16.8%, p < 0.001, and 2% vs. 26.4%, p < 0.001), respectively. Comparing patient vs. proxy EQ-VAS ratings, estimates of perceived HRQOL among patients was found higher (mean score 67 vs. 60, p < 0.001). The comparison between patients' and proxies' estimates of HRQOL and the agreement, according the Spearman's correlation coefficients for EQ-6D subdimensions was sufficient for respectively, self-care (0.724), mobility (0.668), usual activities (0.605); moderate for pain (0.575); and insufficient for cognition (0.333) and anxiety/depression (0.281). The level of agreement between patients' and the proxies' responses for the SF-36 questionnaire was greatest in aspects concerning physical health, and weaker in the mental health dimension. Proxies' responses differed significantly in four dimensions, namely 'general health', 'vitality', 'role emotional', and 'mental health'. **CONCLUSIONS:** Proxy responses give acceptable assessment of a patients' HRQOL before ICU admission.

PMC56

PREFERENCES FOR PREFERENCES

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OBJECTIVES: We assessed the most commonly-used measurement scales for utility weights elicitation in published cost-utility analyses (CUAs) and examined changes in elicitation methods over time. **METHODS:** Our study is based on data on CUAs in the Tufts Medical Center Cost-Effectiveness Analysis Registry (www.cearegistry.org). For each study, we extracted data on the reported utility weight used to construct QALY estimates, including whether it was based on primary or published/secondary data, and the measurement scale used (e.g., EQ-5D, HUI, SF-6D). **RESULTS:** We reviewed 1,149 original CUAs published from 2002 to 2007. A total of 3860 utility weights were reported, of which 2848 (74%) were based on published sources, 832 (22%) came from a primary source, and 122 (3%) weights were based on both primary and secondary data. For 58 weights (1.5%), the data source was not stated or could not be determined. Of weights for which a measurement scale was identified (n = 483), the EQ-5D was used for 341 (71%) of cases, the HUI for 28 (6%), the SF-36/SF-6D for 27(6%), and the QWB for 23 (5%). Use of the EQ-5D increased substantially, from 59% of weights in 2002–2003, to 75% in 2006–2007 (p = 0.0034), whereas use of the SF-6D algorithm to estimate utilities increased from 1% in 2002–2003 to 9% in 2007–2007 (p = 0.0014). The use of the HUI has not changed substantially over time. The EQ-5D dominated all other scales in the UK, The Netherlands, and Sweden (>80% use), while studies from the United States and Canada tended to use a variety of measurement scales. **CONCLUSIONS:** Only one fifth of utility weights reported in CUAs are based on primary data elicitation. There is a strong preference for using the EQ-5D for elicitation of primary utility values.

PMC57

TO MAP OR NOT TO MAP? THE OXFORD HIP SCORE AND EQ-5D COMPARED

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OBJECTIVES: Disease specific measures (DSM) and generic utility measures (GUM) both provide information about the health status of patients. Generally, a DSM tends to provide more descriptive information than a GUM but does not provide a utility. In order to get the best of both worlds, utility weights from a GUM might be linked to DSM health states in a mapping study. The appropriateness of such a mapping approach hinges on the comparability of the information captured by both types of instruments. The aim of this study was to assess the comparability of the information captured by a DSM and a GUM and the validity of obtaining utilities for the DSM via mapping. **METHODS:** We compared the Oxford Hip Score (OHS) and the EQ-5D in patients undergoing total hip replacement using data from the UK PROMs2 study. The comparability of the type of information was assessed using factor analysis and analysis of the correlation matrix. **RESULTS:** Comparing the instruments showed clear differences in the conceptualisation of the two measures. Factor analyses showed that the OHS data can be associated with 3 distinct constructs: one relating to pain, one to movement, one to daily activities. The 12 items of the OHS loaded on 4 of the 5 dimensions of EQ-5D (no OHS items loaded onto the "anxiety/depression" factor). Also, the results of the exploratory and confirmatory factor analyses describe systematically that -compared to EQ-5D- the OHS items are multidimensional by nature and that the same phenomenon is picked up repeatedly by different items. **CONCLUSIONS:** The differences we found between the two types of instruments do not impede the merits of either when used for their own purposes. However, the conceptual differences between the two types of instruments will have a major impact on the way utility values for a DSM are obtained via mapping.

PMC58

EVALUATING THE INFLUENCE OF PHYSICAL ACTIVITY ON THE SOCIAL AND ENVIRONMENTAL DOMAINS OF QUALITY OF LIFE

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OBJECTIVES: Many researches indicate that physical activity can increase well-being and quality of life, specifically the physical and psychological domains of quality of life. The purpose of this study attempts to investigate whether physical activity also has the influence on social and environmental domains of quality of life. **METHODS:** A total of 432 students at National Taiwan University participated in this study. Two questionnaires concerning the physical activity and quality of life (WHOQOL-BREF) were used. Structural equation modeling was conducted to indicate any relationships between physical activity and the social or environmental domains of quality of life. **RESULTS:** The results showed that the two models of predicting social and environmental domains of quality of life from physical activity did not fit the real data well if the standard items of the WHOQOL-BREF were used. However, after deleting some inappropriate items from both (social and environmental) domains of quality of life, significant relationships between physical activity and the two domains of quality of life were noted respectively. **CONCLUSIONS:** The study expects the impact of individual physical activity to his/her social and environmental domains of quality of life. Furthermore, physical activity can enhance not only individual physical and psychological domains of quality of life but also their social and environmental domains of quality of life by deleting some inappropriate items of the WHOQOL-BREF.

PMC59

CULTURAL AND LINGUISTIC ISSUES ASSOCIATED WITH THE TRANSLATION AND LINGUISTIC VALIDATION OF QUESTIONNAIRES FOR USE IN CHINA

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OBJECTIVES: An increasing number of clinical trials are taking place in China. This research aimed to identify some of the issues that may arise as a result of cultural and